**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name and Address**

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

**Respondent Name**

TPCIGA FOR ATLANTIC MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 50

**MFDR Tracking Number**

M4-07-5585-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier has denied this claim due to timely filing. The provider submitted a request for reconsideration on 3/8/07 with proof of timely filing and as of today the provider has not received the carrier final action."

**Amount in Dispute:** $2,907.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "While Carrier can find no record of a timely submission of this bill, Carrier will accept the Requestor's representation that the fax confirmation dated August 7, 2006, at 4:51 pm (the 95th day) was for this bill."

**Response Submitted by:** Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 1, 2006 to May 3, 2006 | Inpatient Hospital Services | $2,907.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee

guidelines for acute care inpatient hospital services.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on April 27, 2007.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F7Y – DATE (S) OF SERVICE EXCEED 95 DAY TIME PERIOD FOR SUBMISSION PER RULE 408.027 AND BULLETIN NO. B-0037-05A. (F286)
   - ZJB – THE CHARGES FOR THIS HOSPITALIZATION HAVE BEEN REDUCED BASED ON THE FEE SCHEDULE ALLOWANCE. (Z695) ANSI – W1
   - W1 – Workers Compensation State Fee Schedule Adjustment.

**Findings**

1. The respondent denied disputed services with denial codes F7Y – "DATE (S) OF SERVICE EXCEED 95 DAY TIME PERIOD FOR SUBMISSION PER RULE 408.027 AND BULLETIN NO. B-0037-05A. (F286)". 28 Texas Administrative Code §133.20(b) states that "A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.3(a) states, in pertinent part, that "Due dates and time periods under this Act shall be computed as follows: (1) computing a period of days. In counting a period of time measured by days, the first day is excluded and the last day is included… (3) unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day. (b) A working day is any day, Monday-Friday, other than a national holiday…" The disputed services involve a 2 day inpatient hospital admission from date of service May 1, 2006 to May 3, 2006. Pursuant to §102.3(a)(1), in calculating the 95th day from the date of this 2 day admission, the first day of the hospital admission (May 1st) is excluded, and May 2nd and May 3rd, 2006, are included. The 95th days following May 2nd and 3rd, 2006, were August 5th and 6th, 2006. However, August 5th and 6th, 2006, fell on a Saturday and a Sunday, respectively. Therefore, pursuant to §102.3(a)(3) the period is extended to include the next working day, which was Monday, August 7, 2006. Review of the submitted information finds documentation to support that a medical bill for the disputed services was submitted to the insurance carrier by facsimile transmission on August 7, 2006. The respondent's position statement asserts that "Carrier will accept the Requestor's representation that the fax confirmation dated August 7, 2006, at 4:51 pm (the 95th day) was for this bill." The Division finds that the requestor has met the timely filing requirement s of §133.20(b). Therefore, pursuant to Texas Labor Code §408.0272, the Division concludes that the requestor has not forfeited the right to reimbursement for the services in this dispute. The respondent's denial reason is not supported. The disputed services will be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Review of the submitted documentation finds that the length of stay was 2 days. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 2 days yields a reimbursement amount of $2,236.00. This amount is recommended.
3. Per former Division rule at 28 TAC §134.401(c)(4)(A)(i), implantables (revenue codes 275, 276, and 278) shall be reimbursed at cost to the hospital plus 10%. Review of the submitted records finds that the health care provider billed revenue code 278 for 3 units. However, no documentation was found to support the cost to the provider of the disputed implantables. Therefore, no reimbursement can be recommended for the disputed implantables.
4. The total recommended reimbursement for the services in this dispute is $2,236.00. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $2,236.00.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that additional reimbursement is due. As a result, the amount ordered is $2,236.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,236.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Grayson Richardson | March 30, 2012 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.